

SAHRN update

Newsletter of the sub-Saharan Harm Reduction Network
Volume 1 (1), September 2008



Editor's Column: Charles Parry

The Sub-Saharan Harm Reduction Network (SAHRN) was formed in October 2007 in Nairobi, Kenya, following a process facilitated by the International Harm Reduction Association (IHRA) with funding from the UK Department for International Development (DFID). This process included civil society organisations working in the drugs (including alcohol) field, researchers, harm reduction advocates, representatives from UNODC, UNAIDS and key donor organisations. Ten countries were represented: Uganda, Nigeria, South Africa, Kenya, Mauritius, Zambia, Seychelles, Liberia, Tanzania and Burkina Faso.

The priorities of SAHRN include capacity development, networking with persons in the region (and other harm reduction networks), establishing a secretariat, influencing policy, advocacy work, and fund raising for specific projects.

The Steering Committee of SAHRN was finalized at the IHRA Conference in Barcelona in May 2008 and includes Fayzal Sulliman (Chair), Lanre Onigbogi (Vice Chair), Charles Parry (Communications), Benjamin Vel (Project Coordinator 1), Rogers Kasiyre (Project Coordinator 2), Rahmaan Lawal, Robert Kutu-Akoi, Kasiyre, Arouna Ouedraogo, Caleb Angira, and Johnny Strijdom. The purpose of the *SAHRN Update* is to promote harm reduction in sub-Saharan Africa (SSA) and to facilitate the work of the network. This and future issues of the SAHRN Update will include reports on projects in SSA, reports on conferences, points of interests, profiles of persons working in harm reduction in SSA, and an input from IHRA.

Report on 19th IHRA in Barcelona (2008): By Lanre Onigbogi

The International Harm Reduction Association's (IHRA) 19th International Conference on Reduction of Drug Related Harm (ICRDRH) of the International Harm Reduction Association (IHRA) took place on 11-15 May in the beautiful city of Barcelona. The conference tagged "Towards a Global Approach" highlighted harm reduction efforts from all parts of the world. The presentations were insightful and gave an idea of the state of harm reduction activities the world over. Of particular importance was the development of the harm reduction movement in Sub-Saharan Africa. The conference gave several harm reduction advocates and researchers from Sub-Saharan Africa the opportunity to gather and showcase the newly formed Sub-Saharan Africa Harm Reduction Network (SAHRN). In total, there were approximately 70 sessions over five days, covering a range of different topics.

The conference was opened with a keynote address by Professor Paul Hunt, the UN Special Rapporteur on the Rights to the Highest Attainable Standard of Health. Professor Hunt delivered a strong statement in support of harm reduction. The first Plenary Session took place on Monday 11th May with presentations on the 'Global State of Harm Reduction'. This session included speakers from Africa, Australia, Europe, Latin America and the International Network of People who Use Drugs (INPUD) and introduced some of the general themes in the conference programme.

The second plenary session was on Tuesday 12th May and featured gender issues in harm reduction, which incorporated video footage with questions to a panel of speakers from around the world. This was followed by Major Sessions on gender barriers, alcohol harm reduction. Wednesday, the 14th May which was the third day featured a Plenary Session and a Major Session on human rights and harm reduction, which will be the main conference theme for Harm Reduction 2009 in Thailand.

The final day, Thursday 15th May opened with a keynote address from Antonio Maria Costa, the Executive Director of the United Nations Office on Drugs and Crime who called for a focus on 'Three HRs': Harm Reduction, Health Responses and Human Rights. The Closing Session featured a review of the Conference by the Rapporteur team.



Chair's column: Fayzal Sulliman

It gives me great pleasure to foreword this first issue of the SAHRN Newsletter. I would like to acknowledge the hard work by the contributors and especially Charles Parry. The unconditional financial and technical support of the IHRA has made the setting up of SAHRN possible.

We are presently working on and defining the legal entity of the network which will have a functional secretariat located in Mauritius at the Dr. Idrice Goomany Centre, an NGO active in the field of harm reduction in Mauritius. The steering committee will play a governing role for the network which will be facilitated by the secretariat.

The goals of the network will be advocacy for harm reduction among sub-Saharan African countries and capacity building in the field of harm reduction. Simultaneously the immediate objective will be to reinforce the network by getting more countries to join in order to achieve these goals. The main challenge will be to ensure the sustainability of the network once the financial support from IHRA ceases. Another major challenge is to advocate for harm reduction in our region where the harm is associated with alcohol use as well as drug use.

Points of interest

Upcoming conferences:

- 20th International Harm Reduction Association Conference in Bangkok, Thailand – 19-23 April 2009

IHRA and the Conference Consortium are pleased to announce the latest in a long-running series of international harm reduction conferences. From the 19th to the 23rd April 2009, the conference will take place at the Queen Sirikit National Convention Centre in **Bangkok, Thailand**. The conference theme will be “Harm Reduction and Human Rights”. As in previous years, this five-day event will include high-profile keynote speakers and a huge range of sessions, workshops, training events, networking events and satellite meetings, as well as an international film festival, poster exhibition and the annual IHRA award presentations.

These conferences have become must attend events for the harm reduction community - the key forum for the dissemination of ideas, research, projects and practice. They have helped to put harm reduction on the map and to coordinate advances, innovations, evidence and advocacy for both the host countries and the other 80 countries that are represented each year.

For further information, please visit www.ihraconferences.net or contact info@ihraconferences.com.

- International Conference on AIDS & STIs in Africa in Dakar, Senegal – 3-7 December 2008
<http://www.icasadakar2008.org/en.php>

Useful websites:

www.ihra.net
www.ahrn.net
www.forward-thinking-on-drugs.org/review2-print.html

Global State of Harm Reduction Report
(Sub-Saharan Africa Section, 742KB):
<http://www.ihra.net/uploads/downloads/Projects/GlobalStateofHR/GSHRSubSaharanAfrica.pdf>

Harm reduction in Mauritius

By Dr Fayzal Sulliman

Injecting drug use (IDU) is becoming an increasingly important mode of HIV transmission globally and available information contradicts the prevailing view that IDU is extremely rare or non-existent in most African countries. IDU populations within selected countries are shown to engage in high-risk sexual and injecting behaviours and have the potential to provide a significant contribution to the spread of HIV and AIDS on the continent. According to the UNODC World Drug Report 2007, Mauritius has the highest annual prevalence of opiate abuse among the population aged 15-64 in Eastern African region and the second highest worldwide.

The HIV/AIDS epidemic in Mauritius is experiencing rapid increase with an annual 100% rise in new infection since 2003. In 2005, the highest annual incidence in 16 years was documented, at 921 new HIV infections. The prevalence in the general population is 0.5% but increases to 15-25% among vulnerable groups such as prison inmates, injecting drug users (IDUs) and commercial sex workers (CSWs). Since 2002, there has been a significant shift in the mode of transmission of the disease from heterosexual to IDUs. In the year 2000, only 2% of the new infected cases of HIV were among IDUs. It has increased to 14% in 2002, 66% in 2003, 87% in 2004 and 92% in 2005 and 85.9% in 2006.

To respond to this challenge, the Mauritian government has taken strong leadership and committed itself to implement a comprehensive set of measures for HIV prevention among IDU, Prison Inmates and Sex Workers. In January 2006, Government approved implementation of **Methadone Substitution Therapy**. The **Methadone Substitution Therapy** is based on the Spanish model. Presently induction is being carried out on an in-patient basis during a two-week period for 15 clients at each entry. Follow up is done by NGOs who provide psycho-social support to the methadone clients in terms of individual and group counselling. Dispensing of methadone during follow up is done at hospital level [seven at present] where special dispensing units have been established to dispense methadone under supervision [directly observed therapy (DOT)] on a daily basis. For the time being no take home dose is being envisaged. To date 1000 IDUs (900 males and 100 females) are currently on Methadone Substitution Therapy and less than 40 have discontinued use. The majority have obtained regular and legal occupations, and positive feedback has been received from IDUs' family members.

In April 2006, The National AIDS Committee (NAC) supported the idea of Needle Exchange Programme as part of the comprehensive national strategy. The **HIV & AIDS Act**, passed by Parliament with non-partisan consensus, on 6th December 2006 is a national policy document & represents an essential unprecedented contribution within a legal framework for targeted approach to HIV prevention among IDUs in Mauritius, with the unequivocal provision for establishment of National Needle Exchange programme. A **Needle Exchange Programme** has been officially launched on 12th November. 2007 with NGO partners.

An audit of harm reduction strategies to address drug-related HIV and AIDS in Southern Africa

By Tara Carney

While the majority of HIV/AIDS transmissions in southern Africa occurs through heterosexual contact, recent studies indicate that substance use plays a substantial role in this. For example, in Botswana, alcohol is associated with multiple risks for HIV transmission such as multiple partners, unprotected sex and transactional sex. In Malawi, results from a rapid assessment found that drug users had multiple partners, did not use condoms and engaged in casual sex. In Cape Town, recent studies found that both adult community populations are more likely to engage in risky sex if they are methamphetamine users. Both adult and adolescent methamphetamine users were more likely to have multiple partners and less likely to use condoms, while adolescents had a higher likelihood of having been/made someone pregnant and been diagnosed with a STI.

There is also some evidence that injection drug use exists in these countries, and is directly linked to HIV/AIDS. In a recent South African study, Injection drug users (IDUs) engaged in risky drug-use practices such as sharing needles, not cleaning needles and re-using needles a multitude of times.

The most commonly used substance in nine of the ten Southern African countries is alcohol. The exception is Malawi, where the primary drug used by patients in treatment is cannabis or 'chamba' (80%). For the remaining countries, cannabis is the second most commonly use substance with the exception of Mozambique, where the percentage of patients receiving treatment for heroin use (33.1%) was only slightly lower than those being treated for alcohol abuse during the last available reporting period (39.1%). South Africa has a number of substances that are widely available and abused, including methamphetamine and heroin (mixed with other substances).

Due to the lack of existing data, it is difficult to conclude whether injection drug use exists in certain countries. For example, while it has been reported in Angola, Mozambique and Zimbabwe there is no up to date data available on this practice. In Botswana, Namibia, Lesotho and Swaziland there have been no official reports of injecting drug use. The most commonly injected drug is heroin while diazepam is also injected in Angola and Zambia, cocaine and methamphetamine reportedly injected in Mozambique and South Africa, and dipipanone hydrochloride is injected in South Africa. Of those in treatment for heroin use, up to 40% inject.

With regards to HIV prevalence among those who inject drugs, this information for the most part is unavailable. The exceptions are Malawi, where a recent rapid assessment found that HIV prevalence was 0% amongst a small subgroup of IDUs, and 25.5% for other drug users. In South Africa, a review of previous studies indicates a prevalence rate between five and 20% amongst IDUs. According to Zambia's National HIV and AIDS Strategic Framework, injection drug use accounts for <1% of HIV transmissions. No information is available regarding Hepatitis C except for one study conducted with IDUs in juvenile centres in Cape Town that found that seven percent were HCV positive. There is a lack of recent and reliable information on the proportion of prisoners with HIV. While recent country presentations presented at Technical meeting on HIV in prisons in Sub-Saharan Africa and a recent report indicated the prevalence rate to be between 60 and 75% for Malawi, and a recent report on HIV and prisons in sub-Saharan African provides reviewed numbers for Zambia (27%) and South Africa (45%), there are no statistics on the other seven countries.

A review of policies related to harm reduction in the region revealed:

- No domestic or international policy that supports or is explicitly opposed to harm reduction exists in any of the countries.
- A demand reduction approach is taken in many countries.
- All 10 countries have a national HIV/AIDS Action Framework.
- Only **Angola, Botswana, Namibia, South Africa, Zambia and Zimbabwe** have frameworks addressing harm reduction.
- Only **South Africa, Zambia and Zimbabwe** briefly mention IDUs.

With regard to harm reduction services in the sub-region:

1. Needle and syringe exchange programmes

Needle and syringe exchange programmes do not exist in these Southern African countries. A current debate exists around whether or not countries that are already resource poor, and do not have reported rates of injection drug use, should focus on obtaining the political will and developing capacity to start these. It is known that in South Africa at least, pharmacies do provide injection equipment but as mentioned in a recent study: the majority of pharmacies are not open at night when users are more likely to need new needles, and if they do purchase their equipment at pharmacies, staff are likely to be judgmental and see them only as "junkies".

2. Drug treatment

In general, opioid substitution therapy (OST) is not available in Sub-Saharan Africa. OST is only available in Botswana for detoxification from alcohol, and in South Africa for detoxification from a number of drugs, such as heroin. Methadone is available as high alcohol-content syrup (Physeptone) while buprenorphine is available at a few private facilities. In general, the provision of OST in Sub-Saharan Africa is impeded by legislation prohibiting the prescription of methadone and buprenorphine, a lack of political will, and weakened health care systems in many countries.

Table 1 indicates a small number of substance treatment sites in these countries, with the exception of South Africa which has a high number of accredited, mostly specialised sites.

Table 1: Drug treatment across 10 countries

Country	Best estimate # of drug dependence treatment sites?	Best estimate # of people in drug dependence treatment?	Best estimate # of IDUs in drug dependence treatment?
Angola	5	1180	0
Botswana	8	992	0
Lesotho	9	63	0
Malawi	7	556	0
Mozambique	5	151	13
Namibia	3	54	0
South Africa	72-120	9412	164
Swaziland	2	223	0
Zambia	3	183	12
Zimbabwe	unknown	unknown	unknown

3. Targeted HIV prevention, treatment and care

While Table 2 indicates that South Africa (\$446 461 994) and Botswana (\$165 000 000) allocate by far the most funding to HIV prevention, treatment and care, it is unknown how much of this budget (if any) is dedicated to IDUs. Only South Africa currently has targeted programmes for IDUs, as information and awareness programmes run by government and civil society that address the link between drug use and HIV are in the early stages of implementation.

HIV prevention, care and treatment services are limited in prisons throughout the region. VCT is available in prisons for most of 10 countries but to varying extents. For example in Botswana, VCT is available to most prisoners while there is just one pilot VCT site operating in Zomba Central prison, Malawi. The availability of condoms also varies widely. For example, they are available in some prisons in Lesotho and most prisons in South Africa (676 621 distributed), but in Botswana, distribution of condoms in prisons is prohibited until release by prison policy, as it is believed that this will promote sexual behaviour in prisons. ART is available in some prisons, such as Botswana (302 people are receiving ART), Lesotho, South Africa (2323 people receiving ART) and Zambia. PMTCT and STI testing and treatment are also reportedly available in Botswana's prisons. In Zambia, a number of NGOs support HIV prevention and care programmes in prisons and in South Africa, there are NGOs and research initiatives that focus on HIV within prisons, which include the provision of harm reduction information for prisoners using drugs.

In conclusion, there is growing evidence of progress in terms of provision of harm reduction services in the sub-region:

- Establishment of SAHRN in Kenya, October 2007.
- Research projects are being undertaken that will provide more information on harm reduction needs and influence service provision for drug users, for example, the rapid assessment, response and evaluation is in South Africa and Mozambique.
- A pilot project to provide VCT two prisoners has been rolled out at the Zomba Central Prison in Malawi.

In order to increase the provision of harm reduction services in southern Africa there is a need for:

- Increasing surveillance to provide information on intravenous drug users
- Learning from the implementation of harm reduction programmes in other resource poor settings
- Lobbying governments to introduce legislation and policy support of harm reduction, rather than criminalising drug users
- Addressing the stigma faced by drug users, but changing cold will attitudes
- Increasing the accessibility of existing harm reduction services (e.g. those in private facilities)
- Facilitating the establishment and activities of drug user organisations.



Members of the SAHRN Steering Committee in Barcelona (from left to right): Benjamin Vel, Rogers Kasire, Fayzal Sulliman, Lanre Onigbogi, and Charles Parry

What is Harm Reduction?

It refers to policies, programmes and projects which aim to reduce the health, social and economic harms associated with the use of psychoactive substances. For example:

- People who inject drugs are vulnerable to contracting blood borne infections such as HIV and hepatitis B and C. Providing sterile needles and syringes helps reduce the risk of infection.
- People dependent on illicit opiate drugs (such as heroin) are at particular risks from impure drugs, overdose, and having to engage in acquisitive crime in order to purchase their drugs. The medical provision of substitute drugs such as methadone and buprenorphine reduces these risks.
- People who become drunk in bars and pubs may cause harm to themselves or others. Training bar staff in responsible serving may help reduce the risk of intoxication and give staff the skills to prevent incidents.
- People who drink and then drive motor vehicles may hurt themselves or others. Drink driving laws, the provision of public transport, and designated driver programmes reduce risks of injury and fatality by separating drinking from driving.

Harm reduction can work alongside approaches that aim for reductions in drug, alcohol and tobacco consumption. However, harm reduction is often a more realistic approach: it recognises that many people throughout the world use psychoactive substances, and that society is unlikely to ever be drug-, drink- or nicotine-free. Harm reduction does not exclude abstinence as a goal for individuals who are dependent but, rather, provides people with more pragmatic choices such as limiting their intake. Harm reduction helps to engage people and motivate them to make contact with treatment providers when they are ready. However, as good treatment and help is unavailable to many people around the world, and many psychoactive substance users may not be ready to engage with treatment services, it is essential from a public health perspective to do what can be done now to reduce harm. (taken from www.ihra.net)

Input from IHRA

By Jamie Bridge

About IHRA

The International Harm Reduction Association (IHRA) is the leading organisation promoting evidence-based harm reduction policies and practices on a global basis for all psychoactive substances (including illicit drugs, tobacco and alcohol). Since being formed in 1996, IHRA has worked closely with the United Nations, international organisations, regional bodies, national governments, civil society, communities and drug user organisations and activists in order to improve public health, protect the human rights of people who use drugs, and advocate for harm reduction approaches (such as needle exchange and substitution treatment). In order to do this, IHRA engages in a wide variety of activities, which can be divided into four broad categories:

Conferences

Each year, IHRA organises a large international harm reduction conference to allow over 1,200 researchers, drug user activists, front-line workers, policy makers and advocates to come together. This series of events has helped to put harm reduction on the map and to co-ordinate advances, innovations, evidence and advocacy for both the host countries and the other 80 countries that are represented each year. Over five days, they are a key forum for the dissemination of harm reduction ideas, research, experiences, projects and practice.

Projects

IHRA engages in a number of specifically funded projects where there is a clear benefit to harm reduction advocacy around the world. The most prominent of these projects is 'HR2 (Harm Reduction and Human Rights)'. Through funding from DFID (the UK Department for International Development), this project aims to monitor the policies and practices of multi-lateral organisations (such as UN agencies and the World Bank). For more information, please visit www.ihra.net/HR2.

Network Building

IHRA has played a key role in the establishment and development of harm reduction networks in a number of regions – such as Latin America, Asia, 'Eurasia', the Middle East and North Africa, and Sub-Saharan Africa. In addition to the regional networks, IHRA has also supported the development of international networks such as the International Network of People who Use Drugs. IHRA also supports these networks to engage with the UN policy-making processes and to work together to create a globally conducive environment for harm reduction.

Research

IHRA also works to improve the evidence-base for harm reduction. Recently, IHRA published a major new report – the 'Global State of Harm Reduction 2008' – which gathered information on drug use, HIV and hepatitis C, and documented harm reduction policies and practices worldwide. In addition, IHRA also creates "50 Best Document Collections" to provide free access to key documents and studies on specific harm reduction topics (including alcohol, tobacco, HIV prevention, and policing). For more information, please visit <http://www.ihra.net/KeyPublications>.

For more information about IHRA, or to become a member, please visit our website (www.ihra.net) or contact Jamie Bridge (jamie.bridge@ihra.net).

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